ATTACHMENT III

_____ REGIONAL SUPPORT NETWORK (AUTHOR. CODE # _____)
CERTIFICATION FOR ADMISSION TO PSYCHIATRIC INPATIENT CARE

NAME:_____ **DATE OF BIRTH:**_____

PATIENT IDENTIFICATION CODE (PIC):_____

COUNTY OF RESIDENCE:_____

NAME OF HOSPITAL:_____

DATE OF ADMISSION TO PSYCHIATRIC INPATIENT CARE:_____

PERSON GIVING CONSENT TO CARE: ❑Client ❑Parent ❑Legal Guardian ❑Other

LEVEL OF INPATIENT CARE NEEDED: ❑ ACUTE AND EMERGENT

❑ ACUTE AND ELECTIVE

On this date, a screening was completed to assess this client's need for inpatient psychiatric treatment. Based on supporting documentation and/or presentation, we certify that the applicant

❑ DOES or ❑ DOES NOT meet the following criteria:

- Age-appropriate application and/or consent requirements are met
- Ambulatory care resources available in the community do not meet the treatment needs of the client
- Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician
- The services can reasonably be expected to improve the client's level of functioning or prevent further regression of functioning, AND
- The client has been diagnosed as having an emotional/behavioral disorder as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association; **OR**
- The client was evaluated and met the criteria for emergency involuntary detention (RCW 71.05 or 71.34) but care was agreed to.
- In addition, for admission to long term inpatient care, the client has been diagnosed with a severe psychiatric disorder which warrants extended care in the most intensive, restrictive setting.

Signatures of team members certifying need for service:

(1) _____ **DATE:**_____ **TIME:**_____

_____**TITLE:**_____
PRINT OR TYPE NAME

(2) _____ **DATE:**_____ **TIME:**_____

_____**TITLE:**_____
PRINT OR TYPE NAME